State of California—Health and Human Services Agency
Department of Health Care Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Please complete the enclosed Medi-Cal provider enrollment application package and return it to the Department of Health Care Services, Provider Enrollment Division, MS 4704, P.O. Box 997413, Sacramento, California, 95899-7413.

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned.

PLEASE NOTE: Applicants and providers are required to submit their National Provider Identifier (NPI) with each Medi-Cal provider application package. Applicants are required to attach a copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation for each NPI listed in the application package. If providers are not eligible to receive an NPI, they should instead enter the word "atypical" in any NPI fields. These "atypical providers" will receive a unique Medi-Cal provider number once the application is approved.

It is your responsibility to report to the DHCS any modifications to information previously submitted within 35 days from the date of the change. Most changes may be reported on a *Medi-Cal Supplemental Changes* (DHCS 6209, rev. 2/08) form. However, you must complete a new application package if you are reporting a change of ownership of 50 percent or more, a change of business address, or one of the other changes identified in Title 22, California Code of Regulations (CCR), Section 51000.30, subsections (a) through (b).

If you are planning to sell your business or buy an existing business, you may find it helpful to refer to the Medi-Cal Provider Enrollment page at **www.medi-cal.ca.gov**. The Provider Enrollment page contains information about enrollment options available to you whenever there is a sale or purchase of a Medi-Cal enrolled provider or business, including the option to submit a *Successor Liability with Joint and Several Liability Agreement*.

Enrollment forms are available at **www.medi-cal.ca.gov** or by contacting the Telephone Service Center at 1-800-541-5555. For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click the “Provider Enrollment” link.

If you have any additional enrollment questions, please contact the Provider Enrollment Message Center at (916) 323-1945, or submit your question(s) to the address above or via email at **PEDCorr@dhcs.ca.gov**. In order to submit claims electronically, providers must request a submitter number by completing the *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHCS 6153, rev. 12/07*),* available on the Medi-Cal Web site at **www.medi-cal.ca.gov** by clicking the "Forms" link in the "Featured" area, then "Billing."

Provider Enrollment Division

Enclosures (Revised 2/08)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL ORTHOTICS AND PROSTHETICS PROVIDER APPLICATION

DO NOT USE staples on this form or on any attachments.

DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date and initial in ink.

DO NOT LEAVE any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

This form is part of an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants and providers may be subject to an on-site inspection and to unannounced visits prior to enrollment or approval for continued enrollment in a program. In addition to this form and requested documentation, a MEDI-CAL DISCLOSURE STATEMENT (DHCS 6207) and a MEDI-CAL PROVIDER AGREEMENT (DHCS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found on the Medi-Cal Web site (www.medi-cal.ca.gov) by clicking the "Provider Enrollment" link.

Omission of any information or documentation on this form or failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Sections 51000.50.

You must attach copies of Centers for Medicare and Medicaid Services/National Plan and Provider Enumeration System (CMS/NPPES) confirmation for each National Provider Identifier (NPI) submitted with your application package. You may not submit an NPI for use in Medi-Cal billing unless that NPI is appropriately registered with CMS and is in compliance with all NPI requirements established by CMS at the time of submission.

Enrollment action requested-check all that apply. Enter the date you are completing the application.

"New provider"—check if the applicant is not currently enrolled with the Medi-Cal program as a provider with an active provider number. Include the NPI for the business address indicated in item 8.

"Change of business address"—check if the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location.

"Additional business address"—check if the applicant is currently enrolled in the Medi-Cal program and is requesting enrollment for an additional business location.

"New Taxpayer ID Number"—check if a new Taxpayer Identification Number (TIN) was issued by the IRS.

"Change of ownership"—check if there is a change of ownership as defined in Title 22, CCR, Section 51000.6.

"Acceptance of Successor Liability with Joint and Several Liability"—check this box only if you are submitting this application pursuant to Title 22, CCR, Section 51000.32 and have already submitted or have enclosed a letter that meets the requirements of Section 51000.32(a)(1).

"Cumulative change of 50 percent or more in person(s) with ownership or control interest" – check if there is a cumulative change of 50 percent or more in the person(s) with ownership or control interest, as defined in Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment.

"Sales of assets (50 percent or more)"—check if 50 percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred.

"Continued Enrollment"—check if the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to Title 22, CCR, Section 51000.55. List active provider number(s) in the space provided.

Check the box labeled "I intend to use my current . . . ." if you intend to use your current provider number to bill for services delivered at this location while this application request is pending. This action places the provider on provisional provider status, pursuant to Title 22, CCR, Section 51000.51.

"Type of entity"—check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, you must attach a legible copy of the partnership agreement. If you check "other", list the type of legal entity.

1. "Legal name" is the name listed with the Internal Revenue Service (IRS).

2. Enter the date of birth of the individual named in number 1.
3. Check the gender of the individual named in number 1.
4. Indicate whether the applicant or provider is a certified Orthotist. If so, provide the certificate number and attach a legible copy of the certificate as issued by the American Board for Certification in Orthotics and Prosthetics or the Board for Orthotist/Prosthetist Certification.
5. Indicate whether the applicant or provider is a certified Prosthetist. If so, provide the certificate number and attach a legible copy of the certificate as issued by the American Board for Certification in Orthotics and Prosthetics or the Board for Orthotist/Prosthetist Certification.
6. "Business name" is the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement to the application.
7. "Business telephone number" is the primary business telephone number used at the business location. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
8. "Business address" is the actual business location including the street name and number, room or suite number, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
9. "Pay-to address" is the address at which the applicant or provider wishes to receive payment. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
10. "Mailing address" is the address at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
11. "Previous business address" is the address where the applicant or provider was previous enrolled. If the applicant or provider is not submitting an application for a change of location, enter N/A.
12. Enter each taxonomy code(s) associated with your NPI. Attach additional sheet(s) if needed.
13. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
14. If the business is a sole proprietorship not using a TIN, provide the social security number of the sole proprietor. (See Privacy Statement on page 5).
15. Enter the driver's license or state-issued identification number and state of issuance of any individual named in number 1. Attach a legible copy to the application.
16. Enter any NPI for the business adress indicated in item 8, registered with other carriers including, but not limited to Medicare. Attach a copy of the CMS/NPPES confirmation for each.
17. Enter the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit.
18. Enter any local business license or permit numbers for any city and/or county where you conduct your business and attach copies to the application. If this does not apply to you, enter N/A and provide an explanation.
19. Enter the requested information. Attach to this application a legible copy(ies) of applicant's/provider's current Certificate(s) of Insurance for Liability Insurance that covers the premises and operation for this address. If all services are provided exclusively in a licensed hospital or licensed health facility (as defined in Health and Safety Code, Section 1250), please provide a cover letter with the facility information as proof of liability insurance coverage in accordance with the February 2005 Provider bulletin regarding Facility-Based Providers.
20. Check the appropriate box to indicate whether you have Worker's Compensation Insurance as required by state law. If applicable, attach proof. If not applicable, check N/A and provide an explanation.
21. "Printed name of provider"—print the last, first, and middle name of the provider as the sole proprietor, partner, corporate officer or government official when applying to the Department of Health Care Services for enrollment or continued enrollment as a provider in the Medi-Cal program.
22. Check the gender of the individual named in number 21.
23. Provide the driver's license or state-issued identification number and state of issuance of the individual named in number 21. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
24. Enter the date of birth of the individual named in number 21.

25. Enter the social security number of the individual named in number 21. (Optional—see Privacy Statement on page 5).

26. An original signature of the individual named in number 21 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed. **See Title 22, California Code of Regulations, Section 51000.30(a)(2)(B) to determine whether you have the authority to sign this application.**

27. The application must be notarized by a Notary Public. The Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

28. To assist in the timely processing of the application package, enter the name, e-mail address, and telephone number of the individual who can be contacted by Provider Enrollment staff to answer questions regarding the application package. Failure to include this information may result in the application being returned deficient for item(s) that an applicant can readily provide by fax or telephone.

✓ Remember to attach a legible copy of the following, if applicable:

- ❒ Driver's license or state-issued identification card
- ❒ Fictitious Business Name Statement
- ❒ TIN verification
- ❒ Seller's Permit
- ❒ Applicable certification(s)
- ❒ Certificate of Liability Insurance
- ❒ Proof of Worker's Compensation Insurance
- ❒ Signed Medi-Cal Disclosure Statement (DHCS 6207)
- ❒ Signed Medi-Cal Provider Agreement (DHCS 6208)
- ❒ Successor Liability Agreement (If applicable)
- ❒ Medicare enrollment verification
- ❒ National Provider Identifier verification (CMS/NPPES confirmation)

MEDI-CAL ORTHOTICS AND PROSTHETICS PROVIDER APPLICATION

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

FOR STATE USE ONLY

- ***Do not use* staples on this form or on any attachments.**
- ***Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.***

Provider number (NPI): _____

Date / /

Enrollment action requested (check all that apply)

- ❒ New provider
- ❒ Change of business address
- ❒ Additional business address
- ❒ New Taxpayer ID Number
- ❒ *Change of ownership (per Title 22, CCR, Section 51000.6)
- ❒ *Acceptance of "Successor Liability with Joint and Several Liability" (per Title 22, CCR, Sections 51000.24.1, 51000.32)
- ❒ *Cumulative change of 50 percent or more in person(s) with ownership or control interest (per Title 22, CCR, Section 51000.15)
- ❒ *Sale of assets (50 percent or more, per Title 22, CCR, Section 51000.30)

For items marked with * indicate effective date: ____/___/_____

- ❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55)
- ❒ I intend to use my current provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51.

* **A provider agreement may not be transferred or assigned to another. However, an applicant may be joined to the provider agreement by strict compliance with the provisions of Title 22, CCR, Section 51000.32 entitled "Requirements for Successor Liability with Joint & Several Liability."**

Indicate the change of ownership effective date: ____/___/_____

Type of entity (check one)

- ❒ Sole proprietor
- ❒ Corporation:
  Corporate number: _____
  State incorporated: _____
- ❒ Partnership (attach legible copy of agreement)
- ❒ Limited liability company (LLC):
  LLC number: _____
  State registered/filed: _____
- ❒ Government entity
- ❒ Nonprofit corporation:
  Type of nonprofit: _____
- ❒ Other: _____

1. Legal name of applicant or provider (as listed with the IRS)

2. Date of birth / /	4. Are you a certified Orthotist? ❒ Yes ❒ No If yes, certificate number (attach a legible copy):	5. Are you a certified Prosthetist? ❒ Yes ❒ No If yes, certificate number (attach a legible copy):
3. Gender ❒ Male ❒ Female		

6. Business name, if different	7. Business telephone number ( )
Is this a fictitious business name? ❒ Yes ❒ No	If yes, list the Fictitious Business Name Statement number (Attach a legible copy of the recorded/stamped Fictitious Business Name Statement.)
	Effective date / /

8. Business address (number, street)	City	County	State	Nine-digit ZIP code
9. Pay-to address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code
10. Mailing address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code

For a change of business address, enter location moving **from**:

11. Previous business address (number, street)	City	State	Nine-digit ZIP code

12. Primary Taxonomy Code	Taxonomy Code	Taxonomy Code
13. Taxpayer Identification Number (TIN) (Attach a legible copy of the IRS form.) __ __ — __ __ __ __ __ __ __	14. Social security number. If sole proprietor not using a TIN, you must disclose this number. (See Privacy Statement on page 6.) __ __ __ — __ __ — __ __ __ __	15. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

16. Medicare/Other NPI (see instructions)	17. Seller's Permit number (attach a legible copy)	18. Any local business license numbers, permits (attach legible copies)

19. **Proof of Liability Insurance—Applicant must attach a copy of their certificate of insurance for the business address.**

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)
	/ /	/ /

Insurance agent's name—(first) (middle) (last) (Jr., Sr., etc.)

Telephone number	Fax number	E-mail address
( )	( )	

20. Does the applicant have Worker's Compensation insurance as required by state law? . . . . . ❒ Yes ❒ No ❒ N/A
If applicable, attach proof of maintenance of Worker's Compensation insurance. If not applicable, check N/A and provide an explanation:

Information About Individual Signing This Application

21. Print name of provider (last) (first) (middle)	22. Gender
	❒ Male ❒ Female

23. Driver's license or state-issued identification number and state of issuance (attach a legible copy)	24. Date of birth	25. Social security number (***Optional***—see Privacy Statement below.)
	/ /	___ ___ ___ – ___ ___ – ___ ___ ___ ___

26. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider pursuant to Title 22, CCR Section 51000.30(a)(2)(B).**

Signature of provider Title

Executed at: _____, _____ on _____
(City) (State) (Date)

27. Notary Public -- This application must be signed by a Notary Public. See instructions for item 27.

28. **Contact Person's Information**

❒ Check here if you are the same person identified in item 21. If you checked the box, provide only the e-mail address and telephone number below.

Contact Person's Name (last) (first) (middle) (gender)

❒ Male ❒ Female

Title/Position	E-mail address	Telephone number
		( )

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945.